

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001755

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 84

FILED JAN 28 1963

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>612 Spruce</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>612 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Arnold Neil</u>			4. DATE OF DEATH Month Day Year <u>1 4 - 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Parsons Trans</u>	9. AGE (last birthday) <u>58</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Neil</u>		13b. MOTHER'S MAIDEN NAME <u>McNeal</u>	
14. NAME OF HUSBAND OR WIFE <u>Iva Neil</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>	
16. SOCIAL SECURITY NO. <u>52</u>		17. INFORMANT <u>Iva Neil 612 Spruce K.C., Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> -carbon monoxide 70% saturation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Test for Carbon monoxide completed</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>Found in burning house</u>	
20c. TIME OF INJURY Hour Month, Day, Year <u>1-4-63</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Residence Kansas City</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Jackson Mo</u>		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh H. Owens Coroner</u>		22b. ADDRESS <u>152 Union Station</u>	
22c. DATE SIGNED <u>1-5-63</u>		23. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/7/1963</u>	
23c. LOCATION (City, town, or county) <u>Kansas City, Mo</u>		24. FUNERAL DIRECTOR <u>C. N. Blackman & Son</u>	
24. ADDRESS <u>U.S.C., Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-7-63</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED
1-14-63INSTEAD OF
70% saturation - suffocationITEM NO. SHOULD READ
18 suffocation-carbon monoxide

DOCUMENT

BY AFFIDAVIT OF Coroner

Hugh H. Owens MEDICAL CERTIFICATION

USE BLACK INK
OR
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Hubert B. Baird

Licensed Embalmer No. 4888

P. O. Address AC 24, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Vertical text on the right margin: "This certificate is not valid unless signed by the embalmer in his own handwriting."